

Discharge to the community nursing service: new insulin and diabetic foot ulcer



Assume that today's date is 21 October 2026. Mr Bates is being discharged home this afternoon. You are a registered nurse on the medical ward at Lakeside Hospital. Using the information in the case notes, write a letter to Ms Jane Ellis, Nurse Unit Manager of the Community Nursing Service, requesting continued care for Mr Bates at home. Address the letter to Ms Jane Ellis, Nurse Unit Manager, Northside Community Nursing Service, 17 Station Road, Northside. In your answer: expand the relevant notes into complete sentences; do not use note form; use letter format. The body of the letter should be approximately 180–200 words.

Choose one box per line: I = Include / C = Compress / O = Omit. Answers and reasons are on the webpage (scan QR).

	I	C	O		I	C	O
Patient details				Admission			
1. Name: Mr Harold Bates	☐	☐	☐	20. Cellulitis resolved; afebrile since 16/10	☐	☐	☐
2. DOB: 04/02/1952 (74 yrs)	☐	☐	☐	Diabetes management			
3. Address: 9 Wattle Court, Northside	☐	☐	☐	21. Insulin glargine commenced 15/10 — current dose 14 units at 08:00 daily	☐	☐	☐
4. Admitted: 13/10/26; discharge: 21/10/26	☐	☐	☐	22. Gliclazide ceased; metformin 1 g BD continued	☐	☐	☐
Social background				23. BGLs 6–11 mmol/L over last 48 hrs; target 6–10 mmol/L before meals	☐	☐	☐
5. Lives with wife (78), who has mild memory problems — unable to assist with insulin or dressings	☐	☐	☐	24. Pt and wife educated about hypoglycaemia; uses meter with large display; hypo treatment at home	☐	☐	☐
6. Retired postman; enjoys lawn bowls	☐	☐	☐	25. Prefers to have breakfast at 07:30 after reading the newspaper	☐	☐	☐
7. Son lives 30 min away, visits weekly	☐	☐	☐	Wound			
8. Single-level home, 2 steps at front door	☐	☐	☐	26. Ulcer 1.5 × 1.0 cm, depth 0.3 cm; granulating; minimal exudate; surrounding skin intact	☐	☐	☐
9. Wife told staff that pt 'never listens to doctors and eats whatever he likes'	☐	☐	☐	27. Dressing: clean with sodium chloride 0.9%, non-adherent foam dressing — change daily	☐	☐	☐
Medical history				28. Must wear offloading shoe when walking	☐	☐	☐
10. Type 2 diabetes (15 yrs); HbA1c 10.2% on admission	☐	☐	☐	29. Physiotherapy: mobilising independently with offloading shoe	☐	☐	☐
11. Diabetic retinopathy — reduced vision; cannot read insulin pen dose window or small print	☐	☐	☐	30. Complained about noise from patient in next bed	☐	☐	☐
12. Peripheral neuropathy both feet	☐	☐	☐	Discharge plan			
13. Hypertension — perindopril 5 mg daily	☐	☐	☐	31. Community nursing daily from 22/10: administer/supervise insulin, check BGL, wound care; if BGL < 4 mmol/L treat per hypoglycaemia protocol, recheck in 15 min and notify GP; report BGL > 15 mmol/L or signs of infection to GP	☐	☐	☐
14. Hypercholesterolaemia — atorvastatin 40 mg nocte	☐	☐	☐	32. GP review 28/10 — insulin titration	☐	☐	☐
15. L total knee replacement 2018	☐	☐	☐	33. High-risk foot clinic (podiatry) 29/10	☐	☐	☐
16. Allergies: nil known	☐	☐	☐	34. Diabetes educator 04/11	☐	☐	☐
Admission							
17. Infected neuropathic ulcer R foot (under 1st metatarsal head) with cellulitis	☐	☐	☐				
18. Foot X-ray: no evidence of osteomyelitis; wound swab: Staphylococcus aureus (methicillin-sensitive)	☐	☐	☐				
19. IV cefazolin 5 days → oral cefalexin 500 mg QID until 28/10/26	☐	☐	☐				